AHRQ Conference: Making New Jersey a Model for Patient Safety August 20, 2003

Facility Patient Safety Practices

Strong Memorial Hospital

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Overall Approach to Patient Safety

- **Promote a culture of patient safety**
- **Enhance education about human error and patient safety**
- **Train staff in safety improvement**
- **Increase reporting of adverse events, near misses and unsafe conditions**
- **Improve communication among providers and patients about safety issues and solutions**
- **Redesign processes that promote patient safety**
- **Implement safe patient technology**
- **Analyze patient safety indicators and provide staff feedback**

How we organize at SMH

- **Patient Safety Executive Committee**
  - **Subset of SMH Management Team**
  - **Conduct 12 Senior Leader Safety Rounds monthly**
- **Medical Error/Risk Management coordinating group – CQO & Dir RM lead, others from QA, OC - weekly**
- **Medication Use coordinating group - weekly**
- **Patient Safety & Risk Management Committee – monthly, multidisciplinary**
- **Project specific teams**

Learning about events

- **On-line web-based incident reporting**
- **Real-time incident report notification via email**
- **Direct communication to management team or office of counsel**
- **SMH "Serious Event Alert" email Group**

(Attachments – SMH Serious Event Flow Chart & DoctorQuality Description)

Finding Events - What's the correct number?

- **RCA Reporting trends**
  - **1998 = 17**
  - **2001 & 2002 = 30**
- **DVT/PE Trackable event rates**
  - **Real-time reporting: 2000 – 28**
  - **Real-time & ICD safety net for 5 months: 2001 – 105**
  - **Real-time & ICD safety net & research methods & increased testing**
    - **2001 1st half - 101**
    - **2001 2nd half - 203**

SMH Reporting Policy

- **SMH reporting policy**
  - **Non-punitive features**
  - **Obligation to report**
  - **Recklessness not excused**
- **Emphasis on systems causes of adverse events**
- **Standard of care: system vs individual**

(Attachment – SMH Reporting Policy)

Root Cause Analysis at SMH

- **Medical Error/Risk Management Coordinating meeting weekly**
- **Deploy mandatory RCA's (NYPORTS, JCAHO)**
- **Deploy internally driven RCA's**
- **Assign RCA leader & facilitator & f/u**
- **Fact-finding vs. kickoff vs. no meeting**
- **30 day turnaround**

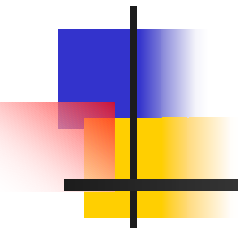
(Attachments – SMH RCA letter & NYPORTS RCA Word document format)

Educating about patient safety - beyond the usual

- Patient Safety Certificate Course
- Crew resource management course
- Obstetrical event communication course
- Patient Simulator – Team training
- Handwriting Course
- Video triggered discussions
  - First Do No Harm
  - First Do No Harm, Part II
  - Josie King Story
- Patient Safety Alerts – topic specific

Best Strategy

- **"Do it right the first time"**
  = "Lean" production
  + "Error-free" performance
- **Optimizes safety (and clinical outcomes)**
- **Optimizes satisfaction (safety or service issue)**
- **Optimizes cost (reduced rework, cost of error)**



Questions?